control is, I think, an important and overlooked part of his medical ethics. To suggest that rules of hospital policy were not motivated by genuine moral concerns is to miss the point of his particular medical expertise. For example, the fact that the rules of hospital admittance were highly selective, is also to ignore the limited purpose and clientele of the voluntary hospital.

The charges of hypocrisy which are implied by such views should perhaps be tested against the alarming contemporary statistics on which the reforming physicians based their blue-prints for more hygienic institutions and their rules for protecting patients within the treacherous walls of the hospitals. For Percival then, the problem of whom to admit and for how long, was, in this sense, not only a procedural issue but a serious moral dilemma for the governors and medical staff alike. Hence, it is in the context of institutional hygiene that we can best understand Percival's attempt to foster more harmonious relations among the medical staff. It was not only personal control over their patients' diets that physicians stood to lose but, more importantly, the patients themselves. At the very least, prudence and self-interest (both kinds) were possible motives.

Percival's desire to establish 'a *committee of the gentlemen* of the *faculty*' appears to have been inspired by his belief that such a group could best influence and educate the managers and governors of the charity concerning the problems they would incur if they persisted in crowding patients into 'close wards' or even permitted patients with contagious diseases like smallpox to be admitted.[160] As he explained:

> There are in-bred diseases which it is the duty of the physician or surgeon to prevent, as far as lies in his power, by a strict and persevering attention to the whole medical polity of the hospital.[161]

Faculty solidarity would, he argued, prevail over the efforts of concerned individuals. He emphasized that, no matter how well intentioned the latter were, their exertions:

> often give rise to jealousy; are opposed by those who have not been consulted; and prove inefficient by wanting the collective energy of numbers.[162]

Professional jealousy, however, was just as inevitable as hospital or jail fever and just as destructive to the aims of the charity if not its patients. It was for this reason that Percival attempted to alleviate some of the most obvious causes of peer rivalry within and without

hospital practice. He warned his colleagues that they should be the guardians of the respectability of their profession. They should avoid 'contumelious representations of the faculty at large; [and] all general charges against their selfishness and improbity'.[163] Medical practitioners should likewise be the guardians of their colleagues' reputations as well as of their own. Consequently, he wrote,

> No physician or surgeon ... should *reveal* occurances [*sic*] in the hospital, which may injure the reputation of any one of his colleagues.[164]

There were, however, restrictions to this rule which Percival subsequently explained. He suggested that if professional charges were made by a physician or surgeon against an associate these should, *before* being made public, be brought before their peers who would 'judge the reasonableness of the case and the measures to be adopted'. In the more contentious cases he suggested that all charges:

> should be referred to the arbitration of a sufficient number of physicians or of surgeons according to the nature of the dispute ... But neither the subject matter of such references, nor the adjudication, should be communicated to the public; as they may be personally injurious to the individuals concerned, and can hardly fail to hurt the general credit of the faculty.[165]

In his chapter on the duties of physicians and surgeons in cases 'which require a knowledge of law',[166] Percival explained briefly how a charge of possible malpractice might be dealt with by the medical profession and the law. His account, however, indicates that such cases were not common and that the charges he referred to in his medical ethics were, more often than not, breaches of etiquette and disputes about clinical judgement. One also gets the impression that a medical reputation could be destroyed or a physician's character impugned for many reasons other than malpractice. Moreover, as Percival noted, it would be most difficult to get a conviction for malpractice because, in order to do so, the prosecution would first have to demonstrate criminal intent. He wrote that:

> When medicines administered to a sick patient, with an honest design, to produce the alleviation of his pain, or cure of his disease, occasion death, this is misadventure, in the view of the law; and the physician or surgeon, who directed them, is not liable to punishment criminally, though a civil action might formerly lie for neglect or ignorance.[167]

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This form of immunity against malpractice was largely confined, he explained, to 'regular' or licensed practitioners. The same action performed by an unauthorized medical person would most likely be viewed as manslaughter. To practise without a licence was, in other words, to risk criminal intent. At this time, moreover, the Royal College of Physicians retained the power invested in them by their royal charter to prosecute, fine and imprison offenders 'pro mala praxi' within their seven-mile jurisdiction.[168]

Percival warned his readers that irrespective of the powers of the law or the Royal College, the final arbiter in these matters must always be the moral law or their own conscience.

> But whatever be the indulgence of the law towards medical practitioners, they are bound by a higher authority than that of the most solemn statute, not to exercise the healing art without due knowledge, tenderness, and discretion: And every rash experiment, every mistake originating from gross inattention, or from that ignorance which necessarily results from defective education, is, in the eye of conscience, a crime both against God and man.[169]

Consultations

No aspect of contemporary medical practice led to so much strife as the problem of consultations. Percival hoped that frequent consultations between the various medical men would, like the institution of faculty meetings, promote harmony as well as knowledge, and with the latter, a new sense of energy and confidence. In his *Medical Ethics* he developed with the help of other hospital staff specific guidelines for every conceivable form of consultation: for 'mixed cases' between physicians and surgeons,[170] for 'special' consultations involving a physician or surgeon objectionable to the patient,[171] for the problem of consultation by letter,[172] for how to behave when hastily summoned to the bedside of a rival's patient,[173] and how, when all have gathered together, to determine the rank of each.[174] He was concerned not only to maintain the traditional hierarchy of physician, surgeon, apothecary, but also to preserve what he described as:

> the regular continuance of the order of precedency established in every town, which might otherwise be liable to troublesome interruptions by new settlers, perhaps not long stationary.[175]

Percival's conservative position regarding the tripartite division of medicine was, however, balanced by the meritocratic stance he shared with most Edinburgh-trained physicians. While he placed

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the highest value on what he called 'a regular academical education', like Gregory he also believed that a university degree was only 'presumptive evidence' of professional ability and not indispensably necessary for the attainment of the requisite knowledge, skill and experience. And, because the good of the patient is the sole aim of all medical consultations,

> the aid of an intelligent practitioner ought to be received with candour and politeness, and his advice adopted, if agreeable to sound judgement and truth.[176]

For the sake of their patients, physicians should consult freely with medical men who lacked the proper qualifications. The trustees of the hospitals, on the other hand, had a duty to hire only those physicians and surgeons who could produce a diploma testifying to their liberal education.[177] Percival was also concerned to maintain the closest possible relationship between the physician and the apothecary (or druggist). It was, he explained, on 'the knowledge, skill and fidelity' of the latter that 'the reputation, success, and usefulness' of the physician depends.[178]

Apart from considerations of etiquette among medical men, Percival's account, like Gregory's, emphasized the role of the apothecary as 'the physician of the poor in all cases, and of the rich when distress or danger is not very great'. This and other arguments in favour of the apothecary's high profits were quoted from *The Wealth of Nations*, whose author he described as 'a political and moral writer of great authority'.[179] Percival's concern that the tripartite division should be maintained could to some extent be derived from the Smithian notion of the efficacy of the division of labour. He certainly agreed with Adam Smith that medicine could best be promoted, not by forming corporations modelled on the Royal College of Physicians in London, but by advancing knowledge, a task done more efficiently and effectively by a medical society such as the London Medical Society formed in 1752 by the Quaker physician, John Fothergill.

Although I have suggested that Percival's manual was much more than a practical guide for the regulation and prevention of intra-professional conflicts, it would be wrong to deny that he was not concerned about this problem. As John Pickstone has so ably shown, he had himself been party to a crisis which resulted in the dissolution of the previous infirmary staff.[180] He was also a close observer and friend of all the contestants in one of the more notorious medical quarrels of his time. In 1788 Erasmus Darwin's

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son Robert and Dr William Withering engaged in a dispute concerning the treatment of a patient. The disagreement began when Dr Withering, the senior physician, was called to treat a former patient of young Dr Darwin. Although the dispute is said to have been over a question of correct clinical judgement, it is evident that the real issue was a problem of etiquette, specifically, the failure to consult the primary physician before prescribing. Robert Darwin, with the assistance of his famous father, mounted a scurrilous attack on Withering whom he accused of adding the insult of slander to the initial injury of not consulting with him. The exchange carried on by the warring partners indicates the acrimonious climate of animosity that Percival's ethics attempted to eliminate. [81]

Robert Darwin published letters to Withering in the form of *An Appeal to the Faculty*, a tactic his antagonist ridiculed. Withering countered that private quarrels such as this were, indeed, best brought before one's peers rather than directly to the attention of the public, as Percival would later advise. Historians of these disputes have shown that while physicians like Robert Darwin aired their grievances in the familiar rhetoric of 'honour', as Percival described it, their quarrels served no good purpose and were almost always left unresolved. Medicine, moreover, could only be damaged by being exposed as an intensely competitive activity in which the patient was viewed as little more than a piece of property to be fought over.

Before we turn to an examination of some of the more familiar topics of medical ethics, it should be noted that Percival, like Gregory, emphasized the moral duty of each physician to view his work scientifically, i.e. in a disinterested or candid manner. How else, he insisted, was medicine to learn from its mistakes?

> it is in a moral view that the practice is here recommended; and it should be performed with the most scrupulous impartiality. Let no self-deception be permitted in the retrospect; and if errors either of omission or commission, are discovered, it behoves that they should be brought fairly and fully to the mental view.[82]

The moral duty to eliminate self-deception was, more often than not, overridden by the doctor's natural tendency to self-protection. How could the medical staff in a public hospital consistently and openly reveal their gravest errors? This was, of course, the dilemma posed so dramatically by Bacon. On the one hand medicine could only progress if the ethos of science, including the disinterested and candid appraisal of one's own and others' procedures, was

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inculcated. But in a climate of intense antagonism and jealousy, as exemplified by the Darwin–Withering quarrel, how could this ideal practice occur? For Gregory, such information would ideally be kept within the scientific community constituted by co-operating physicians, bound to protect each other's professional honour. Percival's attempt to strike a balance was more pragmatic, more troublesome, because it was more open to contest, and, ultimately, perhaps more honest.

The Physician–Patient Relationship

In *Medical Ethics*, neither the patient nor the physician was depicted in isolation. Each had a role (or roles) to play in a manifestly hierarchical society, and each, according to his office or station, had appropriate duties to perform. Illness, as we explained above, was simply viewed as an office in life like any other. Ideally, Percival's hospital patients remained throughout the period of their illness connected by their duties to the web of social relations from which they emerged to seek treatment. Depending on the nature of their illness, they were expected to assist the nursing staff and to perform general housekeeping duties. If they were gravely ill, they had a duty to exercise the passive virtues of patience and forbearance. And because gratitude was the cement of society, all patients were obliged formally to express this virtue upon being discharged, as a further demonstration of their concern for the public good.[163]

The physicians' concern for the general good was similarly demonstrated by their willingness to accept the presence of the patient's family and friends in the hospital wards and sick chambers. Physicians' descriptions of their patients usually included some reference to the patients' families and to the duties owed to them as well as to their patients. Because they believed that it was from the domestic sphere that all individual and civic virtues emerged, a tolerance of family and friends was considered to have been a necessary indulgence. It was thought that a patient set adrift from this morally sustaining milieu, might, in the long run, suffer even greater harm than if he or she had been left untreated.[164] While the patient's family and friends were considered to be a valuable therapeutic agent and the best guarantors of the patient's good character, their status was, nevertheless, an ambiguous one. Increasingly physicians believed that the presence of friends and relations could be both harmful to the patient and an impediment to the progress of scientific medicine.[165]

According to Percival's scheme of ethics, the patients' status was inseparable from their position and role in society. To respect a patient, or to treat a patient as a person, was, essentially, to respect that patient's capacity for fulfilling the duties of his or her particular station. In this view, a physician might best demonstrate respect for his patients by assisting them to return to the scene of their active duties, a goal equally compatible with benevolence and the general welfare of society. Indeed, according to Percival, this would be a 'truly honourable' exertion 'in a cause subservient to the interests of medical science, of commerce and of philanthropy'.

Several problems, however, arose from the belief that the interests of patients and society coincided. Percival's ethics revealed, for example, an unresolved tension between patient benefit and the development of medical science. Put simply, the latter could best be served by encouraging patient compliance and submissiveness. Hospital patients, especially those who could be extricated from their concerned and interfering relatives, were likely to be more submissive than those who were treated in their homes. But the inculcation of these traits tended to make the patients even more dependent on charitable institutions and this development was, Percival believed, decidedly not in the public or private interest. He clearly chose to promote the ideal of the self-regulating over the compliant and possibly dependent patient in order to prevent what he considered to be a much greater social ill. This was one reason why he favoured treating the poor in outpatient facilities such as the dispensaries affiliated with the hospitals. The chief benefit of dispensaries was that they:

> neither tend to counteract that spirit of independence, which should be sedulously fostered in the poor, nor to preclude the practical exercise of those relative duties, 'The charities of father, son and brother', which constitute the strongest moral bonds of society.'[86]

Despite Percival's intentions, the broad concerns of hospital medicine were not always to prove so compatible with the promotion of the self-reliant patient at which his dispensary movement aimed. Moreover, the conflict between individual patient benefit and the broad concern of medical improvement and social utility remained a permanent feature of hospital life and medical ethics discourse, a moral problem which the contemporary issue of clinical experimentation on patients brought into sharper focus.

'The healing art', as John Aikin explained, 'had its original foundation in experiment', and it was the new voluntary hospitals

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that provided the appropriate setting for 'all those gradual steps and minute variations, which contribute to render an experiment both safe and decisive'.[107] The hospital not only provided the ideal institutional setting for medical experimentation, it also offered the ideal experimental subject. As Aikin noted,

> Hospital patients are on several accounts the most proper subjects of an experimental course. The constant superintendence of persons skilled in the management of the sick, and accustomed to obey orders, and the confinement to strict regulations of diet and regimen, are advantages not to be had in an equal degree in private practice, either among the poor or the rich.[108]

Medical experimentation was also more effectively pursued in the new hospitals for it was only here that the practitioner-researcher, free from 'the notice of prying and conceited by-standers ... may exert his genius in any new thought for the benefit of his patient'.[109] Despite his enthusiasm, Aikin was certainly aware that the notion of experimentation was horrifying to many members of the lay community. Whether it was performed on patients, dogs or corpses, the very word *experiment*, Aikin wrote,

> occasions great outcries and prejudices among the vulgar; and ... it is apt to startle some well-disposed persons of a superior class; but as this appears to be owing to wrong ideas hastily taken up concerning the meaning of the term, I do not doubt by a little explanation to render it evident, that such a mode of practice, in the manner in which it ought to be, and really is conducted, is not only defensible, but in the highest degree laudable.[110]

The task of explaining the concept and ethos of what Aikin referred to as 'rational experimentation' to a justifiably suspicious public was one that called for considerable rhetorical skill. Physicians and surgeons had, first, to convince future patients and hospital subscribers that the sick poor would not be needlessly sacrificed; that, in other words, tangible advantage would accrue to the individual patient as well as to the public at large and that patients would not be exposed to unnecessary risks. The deep suspicions of the lay community concerning any form of experimentation, human, animal[111] and post-mortem, forced hospital researchers to demonstrate to the public that they were not callous vivisectionists or wanton defilers of the bodies of their deceased patients. A long tradition of auto-experimentation was repeatedly evoked to remind the public of the traditionally courageous and self-sacrificing actions of medical scientists. Gentleman physicians did not, they insisted,

conduct experiments merely to gratify their scientific curiosity but only for 'the greater good and happiness' of suffering humanity.

Like Aikin, Percival believed that the future of medicine depended on its advancement as a science. He chiefly emphasized the benefits which would eventually accrue to all parties. Medical experimentation was, he argued, clearly in the best interests of the public good:

> and in an especial degree advantageous to the poor ... who, being the most numerous class of society, are the greatest beneficiaries of the healing art.[192]

He warned that all forays into the unknown should be guided by the principles of rational experimentation; by reason, just analogy and documented fact.[193] Like his contemporary, James Gregory (John Gregory's son), he both commended and practised auto-experimentation and, like him too, he doubted whether medical men had 'any right at all to send their patients out of the world that way, who have no ambition for that crown of martyrdom'.[194]

The unpleasant prospect of being viewed as the callous victimizers rather than the benefactors of the poor certainly gave impetus to the creation of regulatory mechanisms for controlling and overseeing hospital experimentation. But, while Percival advocated prior consultation with relevant staff members, he did not consider the explicit consent of the patients themselves. One can only assume that the trust relationship or contract between patient and medical staff encouraged patient acquiescence and provided the moral justification for therapeutic experimentation. According to this contract, the physician was simply assumed to have the moral and technical skill to act in his patient's best interest. If the physician or surgeon had good reasons to believe that a patient's own knowledge concerning a chosen drug treatment, for example, could destroy its benefits or prevent the patient from co-operating, he could, on the basis of the contract, justifiably proceed without the explicit consent of the patient.[195]

Because it was not possible, as Percival explained, to always allow the patients of voluntary hospitals to choose their own doctor, patient trust was often the missing ingredient in the therapeutic relationship. Dissatisfied patients discharged themselves and tried to obtain new recommendations for admittance under the practitioner of their choice. Thus, in order to encourage a more trusting relationship, Percival urged under the rationale of better patient management that such 'partialities' should be indulged whenever

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possible and that their feelings and emotions be known and attended to, 'no less than the symptoms of the disease'. He allowed that:

> Even the *prejudices* of the sick are not to be condemned, or opposed with harshness. For though silenced with authority, they will operate secretly and forcibly on the mind creating fear, anxiety and watchfulness.'[196]

That Percival should find it necessary to warn his colleagues that there was indeed a person behind the disease is a reminder that what appears to be a modern problem is less the result of new technology than endemic to scientific medicine. Neither he nor, indeed, most reputable physicians, wanted to force unwilling or unsuspecting patients to act as the subjects of their experiments. Experiments were, nevertheless, carried out, particularly with new drugs and surgical procedures, and patients were often justifiably distrustful of their practitioner's intentions. Without proper consent or consultation, moreover, only the patient's assumed consent allowed medical experimentation or treatment to be viewed as something other than outright coercion or physical assault.

For Percival, the question of control, responsibility and authority was essentially connected to that of the patient's trust and co-operation. Without the proper exercise of authority there was, indeed, no moral justification for any of the medical practices associated with a modern hospital. Authority and its proper exercise were, consequently, the starting point and *leitmotif* of Percival's medical ethics. All physicians and surgeons, he pronounced, in his opening chapter, should:

> minister to the sick, with due impressions of the importance of their office; reflecting that the ease, the health, and the lives of those committed to their charge depend on their skill, attention, and fidelity. They should study, also, in their deportment, so to unite *tenderness* with *steadiness*, and *condescension* with *authority*, as to inspire the minds of their patients with gratitude, respect, and confidence.[197]

Condescension and authority were chiefly necessary to combat what Percival referred to as 'the prejudices, the caprices and passions of the sick and their relatives'. He also understood that the ability to inspire confidence and respect was directly linked to professional authority and dignity and that this was in the end the most effective medicine a physician had to offer. Condescension and authority were even more necessary for the successful treatment of out-

patients because in this milieu the formidable social gulf between the physician and his humble patients was more pronounced.'[198]

Percival's introductory passage has been viewed by some modern critics as the unfortunate substitution of the physician's authority for what they rightly claim is the chief aim of medical ethics, a concern for the patients' best interests.'[199] This was clearly not his intention and in order to clarify his use of the terms 'condescension' and 'authority' it will be helpful to view this passage in relation to his and Gregory's concept of the ideal physician. Of central importance to this ideal was the nature of the social virtues which shaped the character of a physician. The ideal physician was according to Percival a man whose original generous impulses or 'springs of action' had been strengthened by education and experience. This was, as he noted elsewhere, a union of the heart and the mind which would create the basis for 'true' or lasting sympathy. For example, in the sermon on hospital duties which Percival included in his *Notes*, his son provided a further explanation of the transformation of the so-called 'softer' virtues into the 'calm principles' which underlined and defined the duty of benevolence. For the younger Percival, as for his father, it was the duty of the medical staff to demonstrate that 'Christian condescension may be compatible with professional steadiness and dignity'.[200] Like Gregory he remarked on the tendency of practitioners, who, when faced with repeated scenes of distress, jettisoned their original or natural impulses of pity or sympathy as a means of protecting themselves from the personal anguish caused by their own emotions. Eventually, he noted, these medical men would renounce sympathy as being 'unsuitable to their character and unfavourable to the exercise of their art'. They would, as Percival's critics charged, eventually be forced to substitute raw authority for the duty of compassion to their patients. Percival noted that this behaviour was no longer acceptable to the medical profession and 'different sentiments now prevail'. He explained, moreover, that a distinction must be made between true compassion and 'that unmanly pity which enfeebles the mind'. Genuine sympathy

> rouses the attention of the soul; gives energy to all its powers; suggests expedients in danger; incites to vigorous action in difficulty; and strengthens the hand to execute, with promptitude, the purposes of the head.[201]

For Percival (and his son) the pity which it was the duty of a medical man to repress was a 'turbulent emotion'. The Christian condescension which should be cultivated in its place was, in